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Good morning, Mr. Chairman. I appreciate being able to be here today to discuss the findings of a report just released by the Center for Health Policy Research, Medicare Home Health Services: An Analysis of the Implications of the Balanced Budget Act of 1997 for Access and Quality.. I will briefly summarize the findings and recommendations of that analysis.

Background and Overview

Home health care is an essential service for millions of acutely and chronically ill people, including the nearly 3.3 million elderly and disabled Medicare beneficiaries who used the Medicare home health benefit in 1994. Between 1987 and 1996, expenditures for Medicare home health services experienced unprecedented growth. This growth in spending is attributed primarily to growth in the number of beneficiaries served and in the increase in intensity of care rather than price.

Many factors contributed to this large growth in the number of beneficiaries and services: expanded coverage (accomplished both through legislation and judicial decisions) lifting limits on the number of services beneficiaries could receive and enabling more beneficiaries who need acute care services in the management of chronic illness to qualify for the benefit, an increasingly ill acute care population, and demographic and technological changes making it possible to deliver more sophisticated care at home to an older population.

While less than 10% of the Medicare population uses home health services, the beneficiaries are generally poorer, sicker, predominantly female, more likely to live alone, and have more functional impairments than the Medicare population generally. They can be divided into roughly three equal groups. The first group represents the traditional post hospitalization acute care need and generates approximately 22% of Medicare's home care costs. The second group can be characterized as "medically complex," seriously ill people with unstable medical conditions combined with functional impairments and requiring multiple institutional admissions. This group generates approximately 42.5% of Medicare home health costs. The third group represents beneficiaries who use the home health benefit for acute care services that meet the medical management needs generated by chronic illnesses. They account for 35% of home health expenditures. Taken from these groups is a subset of home health care users who represent extremely high utilization, requiring more than 200 visits per year and accounting for 43% of Medicare's home health costs while comprising 10% of the home care population. These people tend to have extremely complex medical needs combined with serious multiple impairments and multiple episodes of acute hospitalizations.

These statistics demonstrate that the Medicare home health benefit has become a significant safety net for elderly and disabled Americans. The challenge for changes in reimbursement is to reduce unnecessary utilization without adversely affecting the health status of very vulnerable beneficiaries or increasing costs in other health sectors.

Changes in Home Health Payment Under the Balanced Budget Act

In order to slow the expenditure growth in Medicare's home health benefit, the Balanced Budget Act (BBA) implemented changes in reimbursement designed to yield more than $16 billion in savings over a five-year period. In order to achieve these savings, the BBA mandates two payment systems -- an interim payment system that operates from FY 1998-1999, and a new prospective payment system (PPS) to be developed by the Secretary of Health and Human Services according to certain policy objectives and to begin in FY 2000.

The interim payment system potentially creates the most adverse consequences in the BBA; moreover, its interaction with other home health care-related provisions may intensify these effects. Under the interim system, the BBA extends the two year freeze on per visit cost limits imposed in 1994 by assuming that inflation for those two years was zero. Market basket updates resume in 1996. The BBA also reduces the per visit reimbursement formula by reducing the rate to 105% of the national median, from 112% of the national mean. These changes are consistent with traditional Medicare policies to reduce payment on a per visit basis.

In addition to these changes, the interim payment system imposes total payment limits based on an agency's average cost per beneficiary in FY 1994, minus 2%, and adjusted for an agency-specific/ regional blend. In other words, to encourage more efficient utilization, the BBA limits payments for each agency to the per visit limits multiplied by the average number of visits per beneficiary delivered by that agency in FY 1994.

Apart from changes in the payment system, the BBA implemented other permanent changes regarding the structure of and eligibility for the home health benefit that may affect access to services. These include transferring home health payments not associated with a three-day hospitalization to Medicare Part B, basing payment on the costs of the location where services are delivered rather than the costs of the location of the business offices of home health agencies, clarifying the definition of part-time and intermittent care eliminating venipuncture as a service that may qualify beneficiaries for other home care services, and establishing normative standards for service denials.

Impact of the Balanced Budget Act on Home Health Services

Among the many chances in Medicare home health care under the BBA, the interim payment system is likely to have the greatest unintended adverse consequences. The probable results of the interim payment methodology are to create strong incentives to limit or deny care to the sickest beneficiaries, to reward historically inefficient providers, and to make the ultimate PPS system scheduled to take effect in FY 2000 much more difficult to design and implement.

First, because under the BBA, home health agencies can only be reimbursed for the average number of visits per beneficiary in FY 1994, they have strong incentives to limit care to those patients who require no more than the average number of such visits. An agency effectively loses money if its case mix of patients require more visits than the average beneficiary did in FY 1994. Alternatively, agencies can accept such patients but attempt to reduce care to a level as close to the average as possible, regardless of the condition of the, patient. This occurs because the interim payment system contains no case-mix adjuster or other adjustment tool to compensate agencies who care for sicker patients.

Under the interim system, the sickest patients will experience the most problems. This is because this payment methodology creates perverse incentives in the way it attempts to control utilization. While

efficient agencies who care for very sick patients will have higher averages than efficient agencies who care for less sick patients, they may have lower averages than inefficient agencies who care for less sick patients. Efficient providers of care for very ill patients may have to reduce necessary services, serve a healthier clientele, or leave the market. The inefficient agency, on the other hand, can reduce services more easily and still have the financial advantage of an historically higher average. As a result, providers that care for the sickest patients will become less available and those patients may have substantial difficulty being accepted by other agencies.

In addition to creating substantial disincentives to care for sicker and more disabled patients, the interim payment system substitutes an agency-specific total payment methodology for a national payment methodology while - locking in historic differences in practice patterns, both regionally and by agency. This will make it more difficult to move to a final PPS methodology because it will be more difficult to establish normative patterns of service delivery and obtain the data necessary to implement PPS.

The access and quality problems posed for very fragile beneficiaries are compounded by changes in rules governing eligibility for home care services. Specifically, eliminating venipuncture as the threshold by which beneficiaries may qualify for home care services will unquestionably reduce the number of Medicare beneficiaries receiving the benefit. However, it is not clear whether those other services will be available in any other sector for these beneficiaries. For example, it is unclear that state Medicaid programs can accommodate these needs or that other state home care services will be available. The lack of alternative financing and delivery infrastructure suggests that many Medicare beneficiaries will be left without services on which they have depended for the management of chronic illnesses and disabilities.

Restrictions on part-time and intermittent care which are designed to limit the provision of long-term daily care will have similar effects. To the extent that limitations on the duration of care result in more denials of care, sicker beneficiaries may be effectively without coverage for Iong-term acute care management unless state Medicaid agencies elect to fill the void. Given these agencies' own efforts to contain costs, such an expansion may be unlikely.

The main findings of this study can be summarized as follows:

- the home care population represents an increasingly sicker population requiring more acute management of chronic illness and higher intensity acute care;

- the BBA's reductions in Medicare home health coverage and financing can be expected to affect the sickest and highest cost patients and punish the very agencies that specialize in the provision of care to this population;

- the most severe effects of the interim payment system will fall on the sickest patients living in states with the lowest historical utilization patterns;

- the BBA's interim payment system will shift costs to other payers (notably Medicaid) while rewarding inefficient agencies who care for relatively healthier patients; and

- the interim payment system will make it more difficult to design and implement the permanent prospective payment system scheduled to become effective in FY 2000.

Conclusion and Recommendations

Because of the adverse consequences associated with the BBA revisions to the Medicare home care benefit and its payment, this report proposes five options to maintain access to necessary care, reduce excess utilization, and facilitate transition to a final PPS methodology. These options include: (1) a moratorium on the interim payment system coupled with acceleration of the implementation of a case-mix adjusted PPS system; (2) implementation of an interim episode-based PPS system, analogous to the hospital diagnosis-related group (DRG) system, based on current demonstration projects administered by the Health Care Financing Administration (HCFA); (3) implementation of an interim simplified risk-adjusted payment system based on the four categories of spending and use patterns among Medicare beneficiaries described above, notably post-acute, unstable medically complex, stable acute management of chronic illness, and high intensity long term medically complex; (4) implementation of a two-level per beneficiary cost-limit based on short stay or long-stay designations; and (5) reexamination of eligibility and coverage changes included in the BBA.

All of these options substantially reduce the disincentives to deny care to very sick beneficiaries by providing for additional payments for those beneficiaries while providing incentives for less efficient agencies to change practice patterns. Under these approaches, the reimbursement rests on standard payments modified to reflect the illness severity of the patient. In addition, the report recommends phasing in changes in service eligibility or duration to assure that seriously ill patients are not left without sources of care. The goal here is to allow time for alternative infrastructure to develop to care for patients whose care is pushed out of the Medicare system.

The eligibility and payment systems under the BBA fail both the tests of rewarding efficiency and assuring appropriate access to care. The costs of such failure both in social and financial terms are potentially significant, necessitating early revision of the interim payment methodology and a reexamination of coverage requirements.